



## Supervisor's Accident Report

Location where accident occurred:	Venue: Load in: Load out:	Date of accident:
Was injury promptly reported?		Time of accident:      am <input type="checkbox"/> pm <input type="checkbox"/>
Who was injured?	Was first aid provided? By whom? Phone #	Time shift began:  Time shift was to end:
What was employee doing when injury/illness occurred?		
How did injury occur? (Please be as specific as possible)		
Why did it happen?		
Part of body affected/injured:  Any prior physical conditions?	What equipment was involved and/or damaged?	
Nature and extent of injuries: (Please be as specific as possible)		

**PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS**

<input type="checkbox"/> Failure to lockout <input type="checkbox"/> Failure to secure <input type="checkbox"/> Horseplay <input type="checkbox"/> Improper dress <input type="checkbox"/> Improper guarding <input type="checkbox"/> Improper instruction	<input type="checkbox"/> Improper maintenance <input type="checkbox"/> Improper protective equipment <input type="checkbox"/> Inoperative safety device <input type="checkbox"/> Lack of training or skill <input type="checkbox"/> Operating without authority <input type="checkbox"/> Physical or mental impairment	<input type="checkbox"/> Poor Housekeeping <input type="checkbox"/> Poor Ventilation <input type="checkbox"/> Unsafe arrangement or process <input type="checkbox"/> Unsafe equipment <input type="checkbox"/> Unsafe Position <input type="checkbox"/> Other
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What should be done to ensure this type of accident does not recur:

Supervisors Name	Supervisors Signature	Phone #	Date
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### Witness Statement

Name:	Phone #:	Date:
Describe fully how accident occurred: (Please be as specific as possible)		
Signature		